CLAIM FORM FOR
MEDICAL, MENTAL HEALTH & FUNERAL EXPENSES

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT

CVR NUMBER: _____ Victim Name: _____

Claimant Name: _____

Your claim investigator is: _____ Phone: _____

Note: The CVR Board is not responsible for your bills. The board is not to be listed as the guarantor on the bill.

STEP 1. ANSWER THESE QUESTIONS ABOUT YOUR EXPENSES.

1. A. Are you responsible for any of these bills? [ ] Yes [ ] No, then who?_____
   B. If not, have you paid all or part of them anyway? [ ] Yes [ ] No
   NOTE: If you answered NO to questions 1A or 1B; stop here. You cannot submit a claim for this expense.
   If you answered YES to either question, please continue.
2. Complete the following information for all insurance and/or benefit plans which might cover these expenses.

Company Name _____ Phone _____

Policy Number _____ Group Number _____

Address _____
(Street, City, State, & Zip Code)

STEP 2. LIST ALL EXPENSES. Include **itemized** bills from the hospital, doctor, ambulance, dentist, pharmacy, funeral home, cemetery, etc. Do **not** include bills paid in full by your insurance company. Do not write "SEE ATTACHED."

Provider Name	Total Bill	Amount paid by Insurance	Amount paid by Claimant	Amount Owed to Providers

YOU MUST ATTACH A COPY OF THE ITEMIZED BILL **AND** INSURANCE SETTLEMENT FOR EACH EXPENSE CLAIMED.

FOR **MEDICAL TRAVEL**: IDENTIFY MEDICAL PROVIDER, DATES YOU VISITED, MILES ROUND TRIP
(The dates listed below must correspond with the documentation listed above.)

NAME OF MEDICAL PROVIDER	DATES OF VISITS	MILES/ROUND TRIP
_____	_____	_____
_____	_____	_____

SEND THIS FORM AND REQUIRED ATTACHMENTS TO:

STEP 3.SIGN HERE _____

DATE _____